

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 17600	
1. DECEASED NAME (TYPE OR PRINT) Bernard John Amann										2a. DATE KNOWN OF DEATH MONTH 7 DAY 31 YEAR 1979 HOUR 8P	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH Nov. DAY 3 YEAR 1911	6. AGE (IN YEARS) LAST BIRTHDAY 67 YRS.	IF UNDER 1 YR. MONTHS DAYS 	IF UNDER 24 HRS. HOURS MIN 	2c. DATE PRONOUNCED DEAD MONTH 7 DAY 31 YEAR 1979 HOUR 1145P		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		17a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Silk Mill			
10. CITY OR TOWN OF DEATH Westernport		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 1 6 miles North East of Westernport				17b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Silk Mill			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. CITY OR TOWN Allegany		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 218 Poplar St.					
14. FATHER'S NAME FIRST John MIDDLE LAST Amann				15. MOTHER'S MAIDEN NAME FIRST Anna MIDDLE LAST Kady							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 214 07 6994		17. INFORMANT Rosetta Amann		ADDRESS Westernport, Md. 21562					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Exanguination IMMEDIATE CAUSE (a) 956- Self inflicted laceration, deep, left wrist Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) (c) 										19. APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH CERTIFICATE MAILED	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION 				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) 							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE James H. Feaster, Jr.		M.D. James H. Feaster, Jr., M. D.		MEDICAL EXAMINER 107 S. 2nd. St., Oakland, Md.		DATE SIGNED 7-31-1979					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 3, 1979		23c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery		23d. LOCATION CITY OR TOWN Westernport COUNTY Allegany STATE Md.					
25a. DATE REC'D. BY REGISTRAR AUG 6 1979				25b. REGISTRAR'S SIGNATURE Boal's Funeral Service, P.A. Westernport, Md. 21562							



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE-MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										17601 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Mae Fern BITTINGER							2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 7 24 1979		2b. HOUR 6A M		
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 7-27-1928	6. AGE (IN YEARS) LAST BIRTHDAY YRS 50	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7 24 1979	2d. HOUR 11A					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH GARRETT, MD.					
10. CITY OR TOWN OF DEATH Grantsville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 1, Box 13 (Rural)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home				
13a. STATE Maryland		13b. COUNTY Garrett		13c. CITY OR TOWN Grantsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route 1, Box 13			
14. FATHER'S NAME FIRST MIDDLE LAST Paul L. Krause				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ulelah McKenzie							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-26-6726		17. INFORMANT ADDRESS Route 1, Box 13		17. INFORMANT NAME Roy W. Bittinger, Grantsville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma 1579 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Primary site, pancreas (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>James H. Reaster, Jr.</i>			TITLE (SPECIFY) M.D. DEPUTY			MEDICAL EXAMINER			DATE SIGNED 7-24-79		
EXAMINER'S NAME (TYPE OR PRINT) James H. Reaster, Jr., M.D.			ADDRESS 107 S. 2nd. St., Oakland, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7-27-1979		23c. NAME OF CEMETERY OR CREMATORY Grantsville Cemetery, Grantsville, Garrett, Md.			23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <i>W. Lynn Newman</i> ADDRESS Grantsville, Md.			25a. DATE REC'D. BY REGISTRAR JUL 30 1979			25b. REGISTRAR'S SIGNATURE <i>Harry McCreedy</i>					

10011

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. GIVE PAGE 6 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

17602

1. FOR STATE REGISTRAR		2a. DATE KNOWN ESTI- MATED		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2b. DATE KNOWN ESTI- MATED		2b. HOUR	
Susan Jane BOWMAN				7 4 19 79		6A M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	2d. HOUR
Female	White	Oct. 26, 1904	74 YRS.			7 4 19 79	1P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Pennsylvania	USA			Garrett MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Oakland	Star Rt. #1, Box 127	Housewife		Home			
13a. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE	13b. CITY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS			
Md.	Garrett	Oakland		Star Rt. #1, Box 127			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
George ----- Pastorious		Cora ----- Maust					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		215-14-6036		Janis F. Yarnell, See #13 above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis, generalized</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years "
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED			
James H. Feaster, Jr., M. D.		M.D. DEPUTY MEDICAL EXAMINER		7-4-79			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS					
James H. Feaster, Jr., M. D.		107 S. 2nd. St., Oakland, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
burial		7/7/79		Garrett Co. Mem. Gardens		Oakland, Garrett, Maryland	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Bradley A. Stewart		Oakland, Maryland 21550		JUL 10 1979			

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DHMM - 16 50M 1/76
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 1 7 6 0 3		
1. FOR STATE REGISTRAR					REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR		
Ethel S. Brimlow					July 21, 1979					M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		White		July 4, 1890		89 YRS		MONTHS		DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland		U.S.A.				Garrett MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Grantsville		Goodwill Memonite Home				Housewife		Own Home				
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland					Allegany		Frostburg		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Route 1, Shaft	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME							
William Meek					Mary Stewart							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No					214-32-3405		Mrs. Ruth Martin, Detroit, Michigan					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <u>HACVD</u>										20 yrs.		
4029 DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
NONE												
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
none								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
					HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED					21e. PLACE OF INJURY		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> N/A					(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT.</u> , 19 <u>77</u> , to <u>07-21</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>07-20</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE					22c. DATE SIGNED							
Martin M. Rothstein M.D.					07/23/79							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS							
Martin M. Rothstein, M.D.					48 Broadway, Frostburg, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION		23e. STATE		
Burial			July 25, 1979		Frostburg Mem. Pk.			Frostburg, Alleg., Md.				
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Durst Funeral Home, Frostburg, Md.					JUL 27 1979		Ruthy McBrady					

MEDICAL CERTIFICATION

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1991, 23 July

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Sybil Dennis BURD			2a. DATE OF DEATH MONTH DAY YEAR 07-20-79			2b. HOUR 0505 A				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 09-02-03		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett MD.				
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett Co. Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY House of Rep.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Garrett		13c. CITY OR TOWN Swanton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route #2, Box 27	
14. FATHER'S NAME FIRST MIDDLE LAST Luther N. Dennis			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Hess Stewart							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-24-8872		17. INFORMANT ADDRESS Mrs. Marilu C. Rowe, See #13 above					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Colon DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 mos. 12 mos.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from June 5 19 1979 to July 20 19 79 , that (I) (we) last saw the deceased alive on July 19 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Joseph Alvarez M.D.			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED July 26, 79				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Joseph Alvarez, MD			22e. ADDRESS Fourth St., Oakland, Md. 21550							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 7/23/79		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Prin. Georges, Md.			
24. FUNERAL DIRECTOR NAME Bradley A. Stewart			ADDRESS Oakland, Maryland 21550			25a. DATE REC'D. BY REGISTRAR JUL 25 1979		25b. REGISTRAR'S SIGNATURE Anthony M. Brady		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR AT 15 ME (5))
15M 7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 17605

FOR 1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST Donald		MIDDLE Edward		LAST CLOPPER		2b. DATE KNOWN OF DEATH		MONTH 7		DAY 13		YEAR 1979		2d. HOUR 3A	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 19 19		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		MONTH 7		DAY 13		YEAR 1979	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett													
10. CITY OR TOWN OF DEATH Swanton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Swanton Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS Retail													
13a. STATE Md.		13b. COUNTY Garr.		13c. CITY OR TOWN Swanton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route #2, State Pl. Rd.											
14. FATHER'S NAME FIRST MIDDLE LAST Unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Clopper																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, DATE AND OR DATES) WWII		17. INFORMANT Donald Clopper		17a. ADDRESS Rd. #3, Box 328C, Hagerstown, Md.													
MEDICAL CERTIFICATION		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary hemorrhage, massive 1629 DUE TO, OR AS A CONSEQUENCE OF Carcinoma of lung Months (b) DUE TO, OR AS A CONSEQUENCE OF (c)																	
		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE		JAMES H. FEASTER, JR., M.D. - DEPUTY M.D. MEDICAL EXAMINER										DATE SIGNED 7-13-79							
EXAMINER'S NAME (TYPE OR PRINT)		James H. Feaster, Jr., M. D. 107 S. 2nd. St., Oakland, Md.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE													
Burial		7/17/79		Rest Haven Cem.		Hagerstown, Wash., Md.													
24. FUNERAL DIRECTOR'S NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
John O. Durst, Oakland, Md. 21550		JUL 16 1979		[Signature]															

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 17606

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		7-2-79		5:00 AM	
Gertrude Collins							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		White		MONTH DAY YEAR 2-19-27		52 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
W.VA.		USA				Garrett MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Oakland		Cuppett & Weeks Nursing Home, Inc.		Housekeeper			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Garrett		Oakland		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13d. STREET ADDRESS			
FIRST MIDDLE LAST Hervey		FIRST MIDDLE LAST Adeline Moats		Star Rt. # #2, Box 137			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		218-16-2679		Harold Collins		Oak- Star Rt. # 2, Box 127, Land,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
496-		Chr. Obstructive Pulmonary Dis.		yr.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b)					
		DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
Chr. Congestive Failure.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Apr 19 68 to July 19 79, that (I) (we) last saw the deceased alive on 6-30-79 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
B. L. Grant, M.D.						7-2-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
B. L. Grant, M.D.		113 S. 3rd St., Oakland, Maryland 21550					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		7-5-79		Ashby Cemetery		Rt. # 2, Oakland, Md.	
24. FUNERAL DIRECTOR		25a. DATE RECEIVED BY CEMETARY		25b. REGISTRATION NO.			
John R. Wulfehan		JUL 10 1979					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
15M 7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 17607

1. FOR STATE REGISTRAR		2. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Henry Wateman Collins										2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> 7 28 19 79 3P M		2b. HOUR	
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR Dec. 18, 1929		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 7 28 19 79		2d. HOUR 5P M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett MD.									
10. CITY OR TOWN OF DEATH Grantsville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 2, Box 70				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Iron Worker				12b. KIND OF BUSINESS OR INDUSTRY Constr.					
13a. STATE Maryland		13b. COUNTY Garrett		13c. CITY OR TOWN Grantsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route 2, Box 70							
14. FATHER'S NAME FIRST MIDDLE LAST Herbert H. Collins				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Etta B. Van Meter											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		(IF YES, GIVE WAR OR DATES) Korean		16b. SOCIAL SECURITY NO. 213 24 7024		17. INFORMANT ADDRESS Ruby T. Collins, as above									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, left APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4/10 - Hours Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Coronary Thrombosis Hours 1 (c) Coronary Sclerosis H+=====															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Adhesive Pericarditis, Marked															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <i>James H. Reaster, Jr.</i>				TITLE (SPECIFY) M.D. DEPUTY MEDICAL EXAMINER				DATE SIGNED 7-28-79							
EXAMINER'S NAME (TYPE OR PRINT) James H. Reaster, Jr., M.D.				ADDRESS 107 S. 2nd. St., Oakland, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/31/79		23c. NAME OF CEMETERY OR CREMATORY Waxler Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Allegany Co., Md.							
24. FUNERAL DIRECTOR NAME John J. Hafer, Jr. La Vale, Md.				ADDRESS				25a. DATE REC'D. BY REGISTRAR AUG 2 1979		25b. REGISTRAR'S SIGNATURE <i>Henry McBrady</i>					



John J. Hester, Jr., in Vale, 1901.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 17608	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Alan Grenagle EDWARDS										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 7 8 79	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 7 1945		6. AGE (IN YEARS) (LAST BIRTHDAY) 34 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2b. DATE PRONOUNCED DEAD MONTH DAY YEAR 7 8 79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett	
10. CITY OR TOWN OF DEATH Swanton				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Rural Rte. 1				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Builder		12b. KIND OF BUSINESS OR INDUSTRY Construction	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 18100 Cashell Road			
14. FATHER'S NAME FIRST MIDDLE LAST Philip Knox Edwards						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Regina Grenagle					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes				16b. SOCIAL SECURITY NO. 1968		17. INFORMANT Dorothy T. Edwards		ADDRESS same as 13e.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: 9554 IMMEDIATE CAUSE (a) GUNSHOT OF CHEST WITH PENETRATION OF HEART AND RIGHT LUNG Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) (c) (Self inflicted)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1 7 8 79		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Self-inflicted pistol shot to chest					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, WORK, FACTORY, ETC.) Deep Creek Lake		21f. LOCATION Rural Rt. 1 Swanton OR TOWN Garrett COUNTY Maryland					
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										DATE SIGNED 7-8-79	
ACTUAL SIGNATURE James H. Feaster, Jr., M. D.				DEPUTY M.D.				MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS 107 S. 2nd. St., Oakland, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE July 9, 1979		23c. NAME OF CEMETERY OR CREMATORY Lee Funeral Home Crematory		23d. LOCATION City or Town Washington		COUNTY STATE D.C.	
24. FUNERAL DIRECTOR NAME Bradley A. Stewart				ADDRESS Oakland, Maryland 21550		25. DATE RECEIVED BY REGISTRAR (FOR REGISTRAR'S SIGNATURE) JUL 13 1979					



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO. <u>17609</u>						
1. DECEASED NAME (TYPE OR PRINT) IVA PLEASANT Fike			2a. DATE OF DEATH MONTH 7 DAY 1 YEAR 79			2b. HOUR 2:30 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 9 DAY 3 YEAR 1900		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS 3 DAYS HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett MD.			
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dennett Rd. Manor Nurs. Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Garrett			13c. CITY OR TOWN Friendsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Route 1		
14. FATHER'S NAME FIRST Ross MIDDLE Orval LAST Frazee			15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Ann LAST EVANS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-78-0628		17. INFORMANT ADDRESS 218-78-0628 Dawey Fike, Friendsville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT 4292 DUE TO, OR AS A CONSEQUENCE OF b) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Paul Williams						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL P WILLIAMS				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-4-1979		23c. NAME OF CEMETERY OR CREMATORY Webb Chapel Cem.		23d. LOCATION CITY OR TOWN Hazletton COUNTY Preston STATE W. Va.			
24. FUNERAL DIRECTOR NAME D. Lynn Hewshaw ADDRESS Grantsville, Md.				25a. DATE REC'D. BY REGISTRAR III 9 1979		25b. REGISTRAR'S SIGNATURE Barry M. Brady			

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UNITED STATES OF AMERICA
DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 17610	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Clayton Mathias FRAZEE										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR HOUR 7 31 1979 30P	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 12-19-1898	6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 80	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR HOUR 7 31 1979 10P					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett MD.					
10. CITY OR TOWN OF DEATH Friendsville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Star Rt. (Rural)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming			
13a. STATE Maryland		13b. CITY OR TOWN Garrett		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS Star Route, Box 37					
14. FATHER'S NAME FIRST MIDDLE LAST William Frazee				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ora Cuppett							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-01-9738		17. INFORMANT ADDRESS Star Rt. Md. Harriett E. Frazee, Friendsville,							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery disease 4149 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Arteriosclerosis, generalized (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years " "											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>James H. Roaster, Jr.</i>		TITLE (SPECIFY) DEPUTY M.D.				MEDICAL EXAMINER		DATE SIGNED 7-31-79			
EXAMINER'S NAME (TYPE OR PRINT) James H. Roaster, Jr., M. D.		ADDRESS 107 S. 2nd. St., Oakland, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-3-1979		23c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Oakland, Garrett, Md.					
24. FUNERAL DIRECTOR <i>W. Lynn Bowman</i> ADDRESS Grantsville, Md.				25a. DATE REC'D. BY REGISTRAR AUG 6 1979		25b. REGISTRAR'S SIGNATURE <i>W. Lynn Bowman</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			7 9 1 7 6 1 1			REG. NO.			
1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH MONTH DAY YEAR			2b HOUR P M
Meadie Helen FRIEND						July 18, 1979			11:55 P
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		Sept. 12, 1895		83 YRS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
West Virginia		USA				Garrett County MD			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Oakland		Garrett County Memorial Hospital				Housewife		Home	
13a STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS
Maryland			Garrett		Mt. Lake Park		YES		505 L Street
14 FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
William H. Timmerman					Marjorie ----- (Unknown)				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS				
No			212-74-7819		Boyd Friend, Mt. Lake Park, Md. 21550				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 4/49 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Artery Disease</u> 4/9 DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>yrs</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Kidney Failure - uricemia</u>									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Apr 19 68</u> to <u>July 19 79</u> , that (I) (we) last saw the deceased alive on <u>7-18-79</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>B. L. Grant</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>7-19-79</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS						
Dr. B. L. Grant			Oakland, MD 21550						
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
burial			7/21/79		Pleasant Valley Cem.		Oakland, Garrett, Maryland		
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Bradley A. Stewart			Oakland, Maryland 21550			JUL 25 1979		<u>Anthony A. Brady</u>	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 17612			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nellie Elizabeth HOYE										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 7 5 19 79		2b. HOUR 530P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 8 84		6. AGE (IN YEARS) MONTHS DAYS HOURS MIN 94 YRS		IF UNDER 1 YR.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7 5 19 79		7d. HOUR 8P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett MD.			
10. CITY OR TOWN OF DEATH Sang Run				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS) Rt. #2, McHenry, Md.						12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING YEAR) Never Worked		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.				13b. COUNTY Garr.		13c. CITY OR TOWN Sang Run		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. #2, Mc Henry, Md.			
14. FATHER'S NAME FIRST MIDDLE LAST Elija Hoyer										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cornelia Friend			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Ruth Hoyer, same as 13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4149 Coronary artery disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Arteriosclerosis, generalized (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE James H. Feaster, Jr.				TITLE (SPECIFY) DEPUTY				DATE SIGNED 7-5-1979					
EXAMINER'S NAME (TYPE OR PRINT) James H. Feaster, Jr.				M. D. 107 S. 2nd. St., Oakland, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 7/8/79		23c. NAME OF CEMETERY OR CREMATORY Sang Run Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Sang Run, Garr., Md.			
24. FUNERAL DIRECTOR NAME John O. Durst, Oakland, Md. 21550						25a. DATE REC'D. BY REGISTRAR JUL 11 1979				25b. REGISTRAR'S SIGNATURE L. J. McBratney			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 7 9 1 7 6 1 3	
1. FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Merlin Wade LANHAM				2a DATE OF DEATH MONTH DAY YEAR July 30, 1979		2b HOUR 2305P M			
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR December 02, 1904		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Garrett Co., MD.					
10 CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett County Memorial Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bridge Supt.		12b KIND OF BUSINESS OR INDUSTRY Highways Dept. of			
13a STATE W. Va.		13b COUNTY Tucker		13c CITY OR TOWN Davis		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS Rural			
14 FATHER'S NAME FIRST MIDDLE LAST Ulysess Grant Lanham				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Mason							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. 1920-1924		17 INFORMANT Straudie		ADDRESS Lanham Davis, W. Va.					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of prostate glandular tissue</u> 185- DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Hypertensive Cardiac vascular disease - severe</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from <u>6-16-69</u> , 19____, to <u>30 July 1979</u> , that (I) (we) last saw the deceased alive on <u>30 July 1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <u>A. E. Mance</u>				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>31 July 79</u>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. A. E. Mance				22e ADDRESS Oakland, Md. 21550							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Aug. 2, 1979		23c NAME OF CEMETERY OR CREMATORY Buena cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Davis, Tucker W. Va.					
24 FUNERAL DIRECTOR NAME <u>Lester R. Hinkle</u>				ADDRESS Davis, W. Va.		25a DATE REC'D. BY REGISTRAR AUG 08 1979		25b REGISTRAR'S SIGNATURE <u>L. Hinkle</u>			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. SEND COPIES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH-17
(VR A15 ME (5))
15M 7/77

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 17614	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary I. Layman										2b. DATE KNOWN OF DEATH MONTH DAY YEAR HOUR 7 10 19 79 1P	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 18, 1916 62	6. AGE (IN YEARS) LAST BIRTHDAY YRS. 62	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7 10 19 79 7P	2d. DATE OF DEATH MONTH DAY YEAR HOUR 7 10 19 79 7P		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
10. CITY OR TOWN OF DEATH Frostburg		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 2, Box 531				12c. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12d. KIND OF BUSINESS OR INDUSTRY Own Home			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Garrett Frostburg										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Clarence J. Mc Kenzie										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Luella Steinla	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 215-56-9102		17. INFORMANT ADDRESS Anthony Layman, Gilmore, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery disease 4149 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Arteriosclerosis, generalized (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years 11	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James H. Feaster, Jr., M.D.			TITLE (SPECIFY) DEPUTY					DATE SIGNED 7-10-1979			
EXAMINER'S NAME (TYPE OR PRINT) James H. Feaster, Jr., M.D.			ADDRESS 107 S. 2nd. St., Oakland, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7-13-1979		23c. NAME OF CEMETERY OR CREMATORY Finzel Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Finzel, Garrett, Md.				
24. FUNERAL DIRECTOR NAME Durst Funeral Home, Frostburg, Md.			ADDRESS		25a. DATE REC'D. BY REGISTRAR JUL 17 1979		25b. REGISTRAR'S SIGNATURE Anthony McCreedy				

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U.S. National Home, Providence, R.I.

• Mr. J. H. Jones •



1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

7 9 1 7 6 1 5

1. DECEASED NAME (TYPE OR PRINT) Dr. Jack Edward LILLER			2a. DATE OF DEATH MONTH DAY YEAR July 10, 1979			2b. HOUR 6:21A			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 22, 1931		6. AGE (IN YEARS LAST BIRTHDAY) 48		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett Co., MD.			
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett Co. Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dentist		12b. KIND OF BUSINESS OR INDUSTRY Dentistry		
13a. STATE Maryland		13b. COUNTY Garrett		13c. CITY OR TOWN Oakland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Dennett Road	
14. FATHER'S NAME FIRST MIDDLE LAST Lloyd Carl Liller			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hilda Lucille Turner						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korea		17. INFORMANT Mrs. Jack Liller		ADDRESS same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 515- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Dilatant fibrosis / Fibrosis (c) Progressive 7 yrs								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 29									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from July 10, 1979 to July 10, 1979 , that (I) (we) last saw the deceased alive on July 10, 1979 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE H. Johnson				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 7/10/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Thomas G. Johnson				22e. ADDRESS Oakland, Md. 21550					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/12/79		23c. NAME OF CEMETERY OR CREMATORY Garn. Co. Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Oakland Garrett Md.			
24. FUNERAL DIRECTION NAME Robert H. Liller Durst Funeral Home				25a. DATE REC'D. BY REGISTRAR JUL 13 1979		25b. REGISTRAR'S SIGNATURE Robert H. Liller			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 1 7 6 1 6

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Ruth Elaine McCUSKER			2a. DATE OF DEATH MONTH DAY YEAR July 11 1979		2b. HOUR 3:10A M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 11 1922		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett County MD	
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett County Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Pennsylvania		13b. COUNTY Fairchance		13c. CITY OR TOWN Fairchance		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 26 Maple St.		14. FATHER'S NAME FIRST MIDDLE LAST Roy David		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna Britt		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NOT UNKNOWN) (IF YES, GIVE WAR OR DATES) 118	
17. INFORMANT ADDRESS David E. McCusker Jr. 26 Maple St. Fairchance, Pa.		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CENTRAL NERVOUS SYSTEM DAMAGE 4149 DUE TO, OR AS A CONSEQUENCE OF (b) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Paul Williams		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED July 11, 1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Paul Williams		22e. ADDRESS Oakland, MD 21550		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Buried		23b. DATE July 14, 1979	
23c. NAME OF CEMETERY, OR CREMATORY Lafayette Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Brier Hill Pa.		24. FUNERAL DIRECTOR NAME Robert M. Durst		25a. DATE RECORDED BY REG. NO. 25b. JUL 24 1979	
24. FUNERAL HOME Durst Funeral Home		24. ADDRESS Oakland, Md.		25b. Robert M. Durst			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 17617			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					MONTH DAY YEAR		2b. HOUR	
Clement E. McReynolds					7 21 1979					11 30 A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.			
Male		White		Sept. 13 1896		82 YRS.		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Tennessee		USA				GARRETT MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF LAST YEAR)		12b. KIND OF BUSINESS OR INDUSTRY	
OAKLAND		CUPPETT-WEEKS Nursing Home								SALESMAN		Stores	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13b. STREET ADDRESS			
13a. STATE		13b. COUNTY		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS							
MD.		Montgomery		TAKOMA PARK YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		230 Grant Avenue, BETHESDA, MARYLAND							
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME								
THOMAS MCREYNOLDS					(unknown)								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT					ADDRESS	
YES					WW 1		433-01-3958					Bruce S. McReynolds-son (same as 13e)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) Cerebral thrombosis										4292			
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular ischemia										yes			
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic CV Disease										yes			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
				HOUR A.M. MONTH DAY YEAR									
				P.M. 19									
21d. INJURY OCCURRED				21e. PLACE OF INJURY		21f. LOCATION							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from June 19 79, to July 19 79, that (I) (we) last saw the deceased alive on 7-18-79 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE								DEGREE		22c. DATE SIGNED			
B. S. Grant, MD								ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		7-21-79.			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)								22e. ADDRESS					
B. S. Grant, MD								Oakland, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE			
Cremation				7/22/79		Metropolitan Crematory		Alexandria, Va..					
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Warner E. Pumphrey, Inc.				JUL 25 1979		[Signature]							
8434 Ga. Ave., S.S. Md.													

V I C T O R

W. Reynolds

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CHARTER

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7/55/79

Metropolitan Crematory, Alexandria, Va..

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
15M/7/77

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										17618 REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) David Stanley MILLER										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 7 31 19 79	
3. SEX Male 4. RACE White 5. DATE OF BIRTH MONTH DAY YEAR 11-10-1955 6. AGE (IN YEARS) LAST BIRTHDAY YRS. 23 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. 23 YRS. 8. IF UNDER 24 HRS. HOURS MIN. 23 YRS.										2b. HOUR 1A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										2c. DATE PRONOUNCED DEAD 7 31 19 79 2d. HOUR 9A	
9. BALTIMORE CITY OR COUNTY OF DEATH Garrett										MD.	
10. CITY OR TOWN OF DEATH Friendsville 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rural Rt. 1 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic 12b. KIND OF BUSINESS OR INDUSTRY Oil Co.											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Garrett 13c. CITY OR TOWN Friendsville 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS Rt. 1											
14. FATHER'S NAME FIRST MIDDLE LAST Stanley Miller 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Adelia House											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No 16b. SOCIAL SECURITY NO. 218-64-9832 17. INFORMANT Darlene Miller, Friendsville, Md.										ADDRESS Route 1	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed Chest; Fractured Skull DUE TO, OR AS A CONSEQUENCE OF (b) (Single Vehicle Accident) DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION 1 3 5 11 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Operator of truck that wrecked 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 1 3 5 11 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1 3 5 11 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Operator of truck that wrecked											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK Highway 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Highway 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rural Rt. 1, Friendsville Garrett Md.											
22a. I certify that I took charge of the remains described above, held and death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE James H. Reaster, Jr. TITLE (SPECIFY) DEPUTY MEDICAL EXAMINER DATE SIGNED 7-31-79											
EXAMINER'S NAME (TYPE OR PRINT) James H. Reaster, Jr., M.D. ADDRESS 107 S. 2nd. St., Oakland, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 8-2-1979 23c. NAME OF CEMETERY OR CREMATORY Blooming Rose Cem. Friendsville, Garrett, Md. 23d. LOCATION CITY OR TOWN COUNTY STATE Friendsville, Garrett, Md.											
24. FUNERAL DIRECTOR S. Lynne Grant ADDRESS Grantsville, Md. 25a. DATE REC'D. BY REGISTRAR AUG 6 1979 25b. REGISTRAR'S SIGNATURE [Signature]											



— 125 —

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 17619	
1. DECEASED NAME (TYPE OR PRINT) LOUISE E. MORRIS										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 7 12 1979 1:50P	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 12-25-1892	6. AGE (IN YEARS) LAST BIRTHDAY 86 YRS	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 7 12 1979		2d. HOUR 2P			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNA		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Garrett MD.					
10. CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cuppitt-Weeks Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY			
14. FATHER'S NAME FIRST MIDDLE LAST JOHN PHILLIPS										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH NEELY	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 214-05-9435A		17. INFORMANT ADDRESS NURSING HOME					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery disease 4149 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Arteriosclerosis, generalized (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years "	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>		TITLE (SPECIFY) DEPUTY M.D.				MEDICAL EXAMINER		DATE SIGNED 7-12-79			
EXAMINER'S NAME (TYPE OR PRINT) James H. Feaster, Jr., M. D.		ADDRESS 107 S. 2nd. St., Oakland, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7-14-1979		23c. NAME OF CEMETERY OR CREMATORY RESTLAWN MEMORIAL PARK		23d. LOCATION CITY OR TOWN COUNTY STATE LAVALLE ALLEGANY MARYLAND					
24. FUNERAL DIRECTOR NAME ADDRESS LEASURE-STEIN FUNERAL HOME, INC. CUMBERLAND, MD				25a. DATE REC'D. BY REGISTRAR JUL 17 1979		25b. REGISTRAR'S SIGNATURE <i>John H. Feaster</i>					

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1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					7 9 1 7 6 2 0 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Elva Victoria PAUGH					2a. DATE OF DEATH MONTH DAY YEAR July 17/1979			2b. HOUR 2200P M	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Oct. 1, 1900		6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Garrett MD			
10 CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett Co. Memorial Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Garr.		13c. CITY OR TOWN Swanton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 1 Box 25	
14 FATHER'S NAME FIRST MIDDLE LAST Joseph Davis					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Sharpless				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS Lewis Paugh same as 13e					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from July 14, 1979 to July 17, 1979 , that (I) (we) last saw the deceased alive on July 17, 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE DEGREE Herbert H. Leighton M.D.						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 18 July 79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Herbert H. Leighton M.D.					22e. ADDRESS Oakland, Maryland				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/20/79		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Rural Garrett Md.			
24 FUNERAL DIRECTOR NAME Robert H. Durant					25a. DATE REC'D. BY REGISTRAR JUL 22 1979		25b. REGISTRAR'S SIGNATURE Robert H. Durant		
24 FUNERAL HOME Burdock Funeral Home					25b. REGISTRAR'S SIGNATURE Kitzmilller Md.				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please it may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 7 9 1 7 6 2 1							
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE OF DEATH MONTH DAY YEAR 2b HOUR	
Mary Lenore RECKART								07 10 79 8:05 a.m.	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR IF UNDER 24 HRS	
Female		White		12 07 22		56 YRS		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Crellin		USA				Garrett MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							
Oakland		Garrett County Memorial Hospital							
12a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland		Garrett		Hutton				13e STREET ADDRESS	
								Star Rt. 2 Box 15 Oakland, Md.	
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Edison Riley Roy		Hazel A. Markley							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS					
No		214-52-1585		Robert Harsh Bruceton Mills, W.Va.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY:									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i>									<i>weeks</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Polydyspnea</i>									<i>hrs.</i>
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>May</i> 19 <i>75</i> to <i>July</i> 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>7-10-79</i> 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>B. L. Grant</i>				DEGREE				22c. DATE SIGNED <i>7-11-79</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
Dr. B.L. Grant				Oakland, Md. 21550					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		July 12, 1979		Ashby Cemetery		Crellin Garrett Maryland			
24. FUNERAL DIRECTOR NAME				ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Stewart's Funeral Home,				Oakland, Md.		JUL 23 1979		<i>Anthony McCready</i>	

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Virgil Clarence SHAFFER			2a. DATE OF DEATH MONTH DAY YEAR July 8, 1979			2b. HOUR 550 A M				
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Sept. 22, 1901		6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Garrett MD.				
10 CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett Co. Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Miner		12b. KIND OF BUSINESS OR INDUSTRY Coal		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Garrett		13c. CITY OR TOWN Deer Park		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. #3, Box 2	
14 FATHER'S NAME FIRST MIDDLE LAST -----			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret ----- Knotts							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 216-09-9576		17 INFORMANT ADDRESS Robert Shaffer, Oakland, Md. 21550					
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1889 IMMEDIATE CAUSE (a) Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of bladder. DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):										
19a. DATE OF OPERATION 8/6/76		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of bladder				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (the hospital) attended the deceased from Aug 76 19 76 to July 19 79 , that (I) (we) last saw the deceased alive on July 7 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Joseph Alvarez M.D.				DEGREE MD.		22c. DATE SIGNED 7/9/79				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. William Fedde, MD				22e. ADDRESS Fourth St., Oakland, Md. 21550						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 7/10/79		23c. NAME OF CEMETERY OR CREMATORY Garrett Co. Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Oakland, Garrett, Maryland				
24. FUNERAL DIRECTOR NAME ADDRESS Bradley A. Stewart Oakland, Maryland 21550				25a. DATE REC'D. BY REGISTRAR JUL 13 1979		25b. REGISTRAR'S SIGNATURE Richard McCreedy				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 1 7 6 2 3	
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST										2b. HOUR	
Iva Marion SNYDER										7 31 19 79 8A	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		2c. DATE PRONOUNCED DEAD	
Female		White		July 15, 1934		45 YRS.		MONTHS DAYS HOURS MIN		7 31 19 79 830P	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7c. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
West Virginia				USA				9. BALTIMORE CITY OR COUNTY OF DEATH			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Mt. Lake Park				18 O'Brien Street				Housewife			
12b. KIND OF BUSINESS OR INDUSTRY				12c. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12d. KIND OF BUSINESS OR INDUSTRY			
Home				Housewife				Home			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS?	
13a. STATE 13b. COUNTY 13c. CITY OR TOWN										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Md. Garrett Mt. Lake Park										13e. STREET ADDRESS	
										18 O'Brien Street	
14. FATHER'S NAME FIRST MIDDLE LAST										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
Otis ----- Reynolds										Mary Alice Locke	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)										16b. SOCIAL SECURITY NO.	
No										233-50-5042	
17. INFORMANT ADDRESS										Roy Snyder, See #13 above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion, Hours											
410- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Coronary Thrombosis "											
(c) Coronary Sclerosis -----											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
Cardiac Hypertrophy; Hypertensive CV Disease; Acute Failure											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	
										P.M. 19	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
										21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion	
ACTUAL SIGNATURE										TITLE (SPECIFY)	
EXAMINER'S NAME (TYPE OR PRINT)										DATE	
James H. Feaster, Jr., M. D.										7-31-79	
ADDRESS											
107 S. 2nd. St., Oakland, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE	
burial										8/3/79	
23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION CITY OR TOWN COUNTY STATE	
Garrett Co. Mem. Gardens										Oakland, Garrett, Maryland	
24. FUNERAL DIRECTOR NAME										25a. DATE REC'D. BY REGISTRAR	
Bradley A. Stewart										AUG 0 8 1979	
ADDRESS										25b. REGISTRAR'S SIGNATURE	
Oakland, Maryland 21550											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		REG. NO. 7 9 1 7 6 2 4								
1 DECEASED NAME (TYPE OR PRINT)		FIRST Mae		MIDDLE Belle		LAST Steiding		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 23, 1891		6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Garrett MD.				
10. CITY OR TOWN OF DEATH Grantsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Goodwill Mennonite Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Md.		13b. COUNTY Allegany		13c. CITY OR TOWN Grantsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Hotel Dorsey Rd.		
14 FATHER'S NAME FIRST Samuel MIDDLE -- LAST Cunningham		15 MOTHER'S MAIDEN NAME FIRST Rosetta MIDDLE C. LAST Haskins		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-38-7305		17 INFORMANT ADDRESS Mr. Charles A. Steiding 35 E. Queen St. Mc Coole, Md.		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peripheral Vascular Disease 4439 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) 2 weeks 20 Yrs.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from March , 19 79 , to July 10 , 19 79 , that (I) (we) last saw the deceased alive on July 10 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Martin M. Rothstein M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 7/12/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN M. ROTHSTEIN M.D.		22e. ADDRESS 48 BROADWAY - FROSTBURG - Md. 21532								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 14, 1979		23c. NAME OF CEMETERY OR CREMATORY Queens Point Cem.		23d. LOCATION CITY OR TOWN Keyser COUNTY Mineral STATE W. Va.				
23e. FUNERAL DIRECTOR Harold W. McHenry ADDRESS Keyser, W. Va.		23f. DATE REC'D. BY REGISTRAR JUL 16 1979		23g. REGISTRAR'S SIGNATURE Henry McCreedy						

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 1 7 6 2 5

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Mary Christine THAYER			2a DATE OF DEATH MONTH DAY YEAR July 6, 1979			2b HOUR 12:19 ^A			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 07 28 22		6 AGE (IN YEARS LAST BIRTHDAY) 56		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Garrett County MD.			
10 CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett County Memorial Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY Own home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md. 13b COUNTY Garr. 13c CITY OR TOWN Mt. Lake Pk.			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 400 "B" Street				
14 FATHER'S NAME FIRST MIDDLE LAST Thomas Little Compton			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Orpha Slabaugh						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO. 215-18-8334		17 INFORMANT ADDRESS Percy Thayer, same as 13e				
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 410- DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from May 19 79 to July 19 79 , that (I) (we) lost saw the deceased alive on 7-5-79 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE B. L. Grant			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-8-79.	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. B. L. Grant			22e. ADDRESS Oakland, MD 21550						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7/8/79		23c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Oakland, Garr., Md.			
24. FUNERAL DIRECTOR NAME John O. Durst			ADDRESS Oakland, Md. 21550			25a. DATE RECEIVED BY REGISTRAR JUL 11 1979 25b. REGISTRAR'S SIGNATURE John O. Durst			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Step 1

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 1 7 6 2 6

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Truman William WHITACRE			2a DATE OF DEATH MONTH DAY YEAR July 6 1979			2b HOUR 8:00 PM				
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 04 29 03		6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Garrett County MD.				
10 CITY OR TOWN OF DEATH Oakland		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Garrett County Memorial Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) coal miner		12b KIND OF BUSINESS OR INDUSTRY		
13a STATE Maryland			13b COUNTY Garrett		13c CITY OR TOWN Kitzmiller		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS Star Route	
14 FATHER'S NAME FIRST MIDDLE LAST Thomas Whitacre			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Jane Harvey							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-01-6615		17 INFORMANT ADDRESS David A. Burdock Kitzmiller, Md.					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Compensatory Artery Disease. (c) Ray										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Apr 6 1965 to July 6 1979 , that (I) (we) last saw the deceased on July 6 1979 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Dr. B. L. Grant			DEGREE Dr. B. L. Grant			22c. DATE SIGNED 7-6-79				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. B. L. Grant			22e. ADDRESS Oakland, MD 21550							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7 9 79		23c. NAME OF CEMETERY OR CREMATORY IOOF Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Elk Garden Mineral WVa			
24. FUNERAL DIRECTOR NAME David H. Burdock			ADDRESS Kitzmiller, Md.			25a. DATE REC'D. BY REGISTRAR JUL 12 1979		25b. REGISTRAR'S SIGNATURE Robert M. Brady		

MEDICAL CERTIFICATION

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